

PHYSICIAN CERTIFICATE FOR CHILD ANNUITANT

Form Approved
OMB No. 0730-0011
Expires Aug 31, 2006

The public reporting burden for this collection of information is estimated to average 2 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0730-0011). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO: Defense Finance and Accounting Service, US Military Annuitant Pay, PO Box 7131, London, KY 40742-7131

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C., Sections 1435 and 1447; and E.O. 9397.

PRINCIPAL PURPOSE(S): The Survivor Benefit Plan (SBP) and the Retired Serviceman's Family Protection Plan (RSFPP), provide for the coverage of children who are unmarried and incapable of self-support because of mental and/or physical incapacitation. If the incapacitation is temporary, recertification of this incapacitation is required every 2 years when the child annuitant is age 18 or over. This certification is necessary in order to continue payment of the annuity.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records, or information contained therein, may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Internal Revenue Service, the Department of Veterans Affairs, or trustees or guardians of survivors (children). It may also be disclosed for any of the "Blanket Routine Uses" as published at the beginning of the DFAS compilation of systems of record notices.

DISCLOSURE: Voluntary; however, if DFAS does not receive this information, the annuity payments will stop.

NOTE: Penalty for presenting false claims or making false statements in connection with claims is a fine of not more than \$10,000 or imprisonment for not more than 5 years, or both (18 U.S.C. 1001)

1. DECEASED MEMBER'S SSN	2. ANNUITANT'S NAME (Last, First, Middle Initial)	3. DATE OF BIRTH (YYYYMMDD)	4. ANNUITANT'S SSN
5. BRIEF DESCRIPTION OF MEDICAL/PSYCHIATRIC DIAGNOSIS		6. DATE CONDITION BEGAN (YYYYMMDD)	

7. PHYSICIAN'S STATEMENT

a. I have attended the patient for _____ years _____ months.

b. I last examined the patient on: _____

c. In my opinion the patient is (X one or both)

<input type="checkbox"/>	(1) Incapable of self-support for the period _____
<input type="checkbox"/>	(2) Incapable of handling his/her own financial affairs for the period _____

d. In my opinion the incapacity is (X one) ☐ permanent ☐ temporary. If temporary, expected recovery date (YYYYMMDD)

e. I am a licensed

<input type="checkbox"/>	physician or practitioner authorized to practice medicine in the state of _____
<input type="checkbox"/>	psychiatrist authorized to practice medicine in the state of _____

8. I HEREBY CERTIFY THAT THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

a. PRINT PHYSICIAN'S NAME (Last, First, Middle Initial)	b. ADDRESS (Include ZIP Code)
c. SIGNATURE	
d. DATE (YYYYMMDD)	